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## AUTHORIZATION FOR RELEASE OF MEDICAL CARE

DATE: \_\_\_\_\_

I hereby authorize Jerry S. Givens, M.D. to release information of my medical care, and/or non specific information example: appointment time, date, or leave message on answering machine.

I further release Jerry S. Givens, M.D. from responsibility for any deleterious effect the review of my office medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own interpretation and that of \_\_\_\_\_ the medical information contained therein and hold blameless Jerry S. Givens, M.D. for conclusions or opinions drawn from said records. I realize by the receipt of these medical records that I am accepting responsibility for protection of my own right of privileged confidentiality.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Print Name of Person obtaining information

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness (Office staff)